

PROVIDER'S GUIDE TO THE FIRST HEALTH AUTHORIZATION PROCESS

Note: This guide does not take the place of the First Health Provider Manual. Instead, this guide will provide suggestions and easy-to-understand explanations of the authorization process in an effort to assist mental health providers in documenting the need for services in the most thorough and efficient manner.

This document was produced by the First Health Montana Regional Care Coordinators, in conjunction with the First Health Clinical Review Staff and the State of Montana Addictive and Mental Disorders Division.

For additional information or to download forms, please consult the following websites

<https://montana.fhsc.com>

OR

<http://www.dphhs.mt.gov>

Go to the "Services" section

Click on Applications and Forms link

Click on Mental Health Services Forms link

This will bring you to the First Health Manual and Forms page

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Updated April 2006

I. IMPORTANT PHONE NUMBERS AND CONTACTS

State of Montana Children's Mental Health Division

Pete Surdock, Bureau Chief	406 444-1290
Veronica Whitaker, Program Officer	406-444-1822
Mary Munger, Finance Officer	406-444-1571
Karin Billings, Field Unit Supervisor	406-444-7064
Lynn Jennings, Program Officer	406-444-3819
Kari Tutwiler, Program Officer	406-444-3814
Sandy Van Campen, Program Officer	406-444-1535
Sharon Odden, Program Officer	406-268-3742
Cindy Erler, Program Officer	406-329-1594
Walt Wagenhals, Program Officer	406-657-3120
Novelene Martin, Program Officer	406-232-0870
Jamie Stolte, Program Officer	406-444-7392

First Health Services of Montana (Montana-based Staff)

Helena office:	111 N. Last Chance Gulch	Toll Free:	(866) 545-9428
	Helena, MT 59601	Local:	(406) 449-2331
		Fax:	(406) 449-6253

Tim Kober, Program Director	Direct Phone: (406) 268-1592
	Fax: (406) 268-1770
	Cellular: (406) 788-8968
	tjkober@bresnan.net

Tami Haux, Customer Service Rep.	Direct Phone: (406) 449-2331
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First Health Services of Montana--Regional Care Coordinators

CHILDREN'S CARE COORDINATORS	
Julie Prigmore (Regions 1 & 2) Great Falls Office Phone: (406) 771-1951 Fax: (406) 727-0115 Cellular: (406) 781-1521 Email: julieprigmore@bresnan.net	Lowell Luke (Region 4) Helena Office Phone: (406) 449-6605 Fax: (406) 449-4646 Cellular: (406) 431-2839 Email: lhluke@fhsc.com
Maureen Roy (Region 5) Missoula Office Phone: (406) 721-8335 Fax: (406) 721-8536 Cellular: (406) 240-6050 Email: maureenaroy@aol.com	Carel Schneider (Region 5) Kalispell Office Phone: (406) 728-0334 Fax: (406) 549-0531 Cellular: (406) 546-2655 Email: cschneider@montana.com
Vonda Nicholson (Region 1 & 3) Billings Office Phone: (406) 252-2870 Fax: (406) 534-2548 Cellular: (406) 670-1288 Email: vnicholson@bresnan.net	

ADULT CARE COORDINATORS	
Gene Durand (Western Region) Phone: (406) 273-2000 Fax: (406) 273-2087 Cellular: (406) 370-6756 Email: Roadkilt03@aol.com	Heidi Spritzer Phone: (406) 465-0370 Fax: 866-204-6994 Cellular: (406) 465-0370 Email: heidispritzer@fhsc.com

First Health Services of Montana—Clinical Review Staff (Richmond-based Staff):

4300 Cox Road
Glen Allen, VA 23060

Toll Free: (800) 598-6462
Reviewer Direct Line: (800) 770-3084
Reviewer Fax Line: (800) 639-8982

II. FIRST HEALTH UTILIZATION REVIEW SERVICES

First Health Services of Montana has been performing utilization review for the State of Montana's public mental health system since November of 2000. Utilization Review is the process by which a provider receives authorization for payment after submitting current clinical information on a recipient for review to our Corporate office clinicians. Those clinicians review the information and determine if the recipient meets the "medical necessity guidelines" (otherwise known as the "clinical management guidelines") established by the State for the particular service being requested. If there are questions regarding the "medical necessity" of a service, the recipient's file is reviewed by a Board Certified psychiatrist who makes a determination on the request. This process is commonly known as a physician deferral. The notification of the deferral is also received by one of six Montana Regional Care Coordinators. The Regional Care Coordinator will notify the provider that the review has been deferred and offer assistance in eliciting any further information that might be relevant for consideration by the psychiatrist. The Regional Care Coordinators assist providers, case managers, recipients and families in accomplishing transitions from one level of care to another in the smoothest manner possible.

What First Health Does Review:	What First Health Does Not Review:
Acute Inpatient Services (youth and adult) Montana State Hospital Acute Care (18 yrs –21 yrs old) Adult Crisis Stabilization Services Acute Partial Hospital Care Services Sub-acute Partial Hospital Care Services Therapeutic Living Services (youth only) Outpatient Therapy Services (youth only)	Therapeutic Living Services (adult) Comprehensive School and Community Treatment Outpatient Therapy Services (adult) MHSP Clinical Eligibility

The levels of care for which First Health offers certification/utilization review are as follows:

Acute Inpatient Services are provided for Medicaid recipients only. A prior authorization is required to be submitted within 24 hours of an admission. A Certificate of Need (CON) from the provider is required for those recipients under 21. Reimbursement for in-state services are based on diagnosis related group (DRG) and do not require a continued stay review. Reimbursement for out-of-state services are reimbursed on a per diem basis and require a continued stay review. Notification of discharge must be provided to First Health within five days of discharge. For in-state admissions, an authorization number will not be issued until the notification of discharge is received.

Montana State Hospital Acute Care requires a prior authorization request to be submitted within 3 business days of admission. For those admissions of individuals under 21, a CON is required. A discharge notification must be submitted to First Health within 5 business days after discharge.

Youth Residential Treatment requires a prior authorization and a CON to be submitted a minimum of 48 hours prior to admission. The CON requires the signature of an intensive case manager employed by a mental health center. For RTC placements in an out-of-state facility, verification of unavailability/unsuitability of in-state services from the three Montana RTCs must be submitted in addition to the required documentation. Continued stay requests must be submitted five days prior to the expiration of the current span of authorized service for continued care in an RTC, accompanied by a re-certification of the CON. Discharge notification is required within 5 business days after discharge. Regional Care Coordinators are required to attend RTC treatment team meetings, either on-site or via telephone, at regular intervals throughout a child's admission.

Adult Crisis Stabilization Services require an authorization request to be sent to First Health with 24 hours or one business day of the admission. Continued stay authorization must be requested 24 hours prior to the termination of the initial certification. A discharge notification must be submitted within 5 business days after the discharge.

Acute Partial Hospital Care Services are co-located with a general hospital with a distinct psychiatric unit or co-located with an inpatient psychiatric hospital for individuals under 21. Partial hospitalization requires a prior authorization request and a completed CON to be submitted to First Health within 48 hours or two business days prior to admission. Continued stay requests must be submitted 5 business days prior to the termination of the initial certification (a new CON is not required for continued stay requests). For individuals stepping down from Acute Inpatient within the same facility, the acute inpatient CON (for individuals under age 21) or a facility-based CON will be accepted with the addition of a signature by the intensive case manager. Discharge notification is required within 5 business days.

Sub-acute Partial Hospital Care is not co-located with a hospital and can serve as either a step down from inpatient hospitalization or residential treatment, or a diversion from higher levels of care. Sub-acute partial hospitalization requires the same prior authorization and continued stay authorizations as acute partial hospitalization. A discharge notification is also required within 5 business days after discharge.

Therapeutic Living Services (Therapeutic Family Care and Therapeutic Group Care) require prior authorization and completed CON signed by the intensive case manager (for individuals under 21) at least 48 hours prior to admission. Continued stay reviews must be submitted 5 days prior to the termination of the current authorization. A discharge notification is required within 5 business days when a recipient leaves this level of care.

Outpatient Therapy Services represent community-based treatment that includes CPT codes 90804, 90806, 90810, 90812, 90846, and 90847. First Health is contracted to provide utilization review to eligible youth recipients who meet SED criteria. Outpatient therapy services must be provided by individuals who are licensed by the State of Montana. This level of treatment intervention includes a consideration of the person's safety and security needs and includes the likelihood of the person to benefit from outpatient treatment. The recipient may receive up to twenty-four (24) outpatient sessions per fiscal year (July 1 – June 30) without prior authorization. If it has been determined that the recipient would benefit from additional sessions, the licensed mental health professional or agency must seek prior authorization prior to receiving additional sessions. Prior authorizations should be submitted two weeks (10 business days) prior to the use of the last of the twenty-four (24) outpatient sessions. Certifications are offered in 90 days spans (calendar days). Providers should be aware that certification will only be granted until June 30th if requested within 90 days of the end of the fiscal year. The number of sessions requested in such cases should be adjusted accordingly.

III. THE ROLE OF THE REGIONAL CARE COORDINATOR

The primary role of the First Health Regional Care Coordinator is to facilitate comprehensive interagency treatment planning through a process of collaboration with providers and other stakeholders. Every effort is made to establish relationships with mental health providers, advocacy organizations, personnel in the juvenile justice, child welfare, education and social service agencies.

In performing day-to-day care coordination responsibilities, effective communication needs to occur, not only between local stakeholders and the Regional Care Coordinator, but also with the First Health Clinical Reviewers and psychiatric staff. The findings and recommendations of the Regional Care Coordinators are routinely communicated to the First Health clinical review staff. While their roles are differentiated, Regional Care Coordinators and clinical reviewers work seamlessly as a team, sharing a common database for all encounters. Clinical information, prior authorization requests, and determinations are captured in an electronic record, regularly updated and accessible by either staff member.

The Regional Care Coordinators have first-hand knowledge of all community resources available, and work in close communication with the clinical review staff to provide a community perspective to requests for authorization. Our electronic database records the current status of each review and every effort is made to ensure that requests for authorizations that raise questions for the reviewer are referred to a Regional Care Coordinator to obtain additional information.

Part of what makes the Regional Care Coordinator job complex is the responsibility to several constituencies. First Health is the employer. It is incumbent upon the Regional Care Coordinator to assist the First Health Clinical Reviewers in any way possible in the task of reviewing cases and evaluating certification for services. A request for assistance from a First Health Clinical Reviewer takes top priority. Communication back to First Health should be timely and thorough and frequent updates may be necessary until the case is resolved. The reviewers also rely upon the Regional Care Coordinators to provide them with information about the availability of services in a particular community or for a particular recipient.

First Health is a vendor of the State of Montana Addictive and Mental Disorders Division (AMDD); therefore AMDD is also a Regional Care Coordinator constituent. Regional Care Coordinators need to provide information to AMDD and to accomplish tasks for this agency. Some examples of this work include the research completed on the “high dollar kids”, researching the demographics of the 16-18 year olds, and providing consultation on the Child and Adolescent Functional Assessment Scale (CAFAS). Regional Care Coordinators work with the AMDD to assist in communicating expectations with regard to the provision of services. The Regional Care Coordinators also provide input as requested during Administrative Reviews conducted by AMDD.

The local community is another constituent. The Regional Care Coordinators are consulted by agencies and providers to inquire about up-to-date information in the current mental health system. The local providers look to the Regional Care Coordinator for assistance with the authorization process. Case managers look to Regional Care Coordinators for assistance with difficult cases. At times, families look to us to assist with access to services. Agencies look to us to take a role in multi-agency service planning.

Major Tasks of the Regional Care Coordinator:

INTERAGENCY/PROVIDER COLLABORATION

1. Meet with all providers in the area. Assist them in understanding the Prior Authorization, Continued Stay, and Appeals processes. Provide training as necessary.
2. Encourage the use of least restrictive services as appropriate.
3. Encourage timely and intentional discharge planning and active work towards discharge.

4. Routinely attend clinical staffings to gain a better working knowledge of the provider's services, bed availability.
5. Be prepared to provide accurate information on changes within the system.
6. Maintain accessibility to providers regarding system or client-specific issues and questions.

LIAISON TO FIRST HEALTH CLINICAL REVIEWERS AND PHYSICIANS

1. Receive referrals, document contacts and resolution of referral to reviewer and the Montana office.
2. Provide additional information to First Health psychiatrists, as requested, when a request for authorization has been deferred.
3. Provide information to reviewers regarding availability of services, barriers to discharge.
4. Encourage providers to communicate accurate, thorough clinical information to the reviewers.
5. Keep reviewers updated on changes that take place regarding the referral.
6. Identify training needs of providers through feedback from the reviewers.

RESOURCE TO CASE MANAGERS

1. Stay abreast of bed availability in various levels of care.
2. Network with other Care Coordinators for information within their respective regions.
3. Assist with placement and step-down planning for difficult-to-place youth.
4. Attend treatment team meetings to assist in case planning, consult on placement issues, and assist with active discharge planning.
5. Assist the Youth Case Managers in gaining clinical documentation from facilities, monitoring treatment (including family therapy), making sure the diagnoses are correct and consistent, and that discharge planning is moving forward consistent with the needs of the child, not the facility.
6. Provide training as needed (e.g., CAFAS, admission and discharge criteria, accountability and documentation.)

SYSTEM COORDINATION AND COLLABORATION

1. Attend Placement Committee in each county as possible.
2. Meet with all stakeholders and placing agencies (chiefly DCFS and Youth Court) to assist in understanding their roles in joint placements, discharge planning, and the authorization and appeals processes. Help them to be alert to the possible need for discharge when a deferral or a partial approval is received.
3. Meet with other parts of the human services system, such as the Chemical Dependency and Developmental Disabilities providers, to facilitate collaboration. Encourage multi-agency service delivery.
4. Attend inter-agency community meetings. Assist with long and short-term strategies to meet the needs of youth in order to identify the needs for services within the region.
5. Attend RTC treatment team meetings on a routine basis (normally at admission, then every few months thereafter)

RESOURCE TO THE STATE

1. Provide accurate, thorough information to the State on the delivery of services in the region.
2. Provide accurate, thorough information to the State regarding specific youth as needed.
3. Act as a vehicle for communication between the State and providers and community members.
4. Provide training as needed to providers.
5. Identify service gaps. Be specific about the numbers, hard to place populations and possible resources.
6. Assist with the regionalization of the mental health system, as requested by the State.

IV. THE AUTHORIZATION PROCESS

The Prior Authorization Request/Continued Stay Request for a level of care is received either by fax or mail.

First Health Clinical Review Staff reviews the document for demographics; qualifying diagnoses, reported description of the recipient's current clinical presentation and treatment needs, medications, co-occurring substance abuse, legal issues, and discharge plan. If questions are not raised regarding "medical necessity", the clinical review is completed and entered into the system.

If questions are raised during the review with regard to the recipient meeting the "medical necessity criteria", the Clinical Review Staff will attempt to contact the provider to address these questions. The provider has five (5) business days to return contact and address the needed information. If within those five (5) business days, contact is made and questions are answered, the clinical review is completed and entered into the system. If within those five (5) business days contact is not made and the questions raised are not answered, an Administrative Denial will be administered for protocol non-compliance.

If questions regarding the "medical necessity criteria" remain after the Clinical Review Staff contact the provider, the submitted information is forwarded to a Board Certified psychiatrist for determination and is usually referred to a Montana Regional Care Coordinator at the same time. This is commonly known as a physician deferral. The Regional Care Coordinator will contact the provider to determine if any critical information was omitted in the review request. The Regional Care Coordinator may then submit that information to the electronic file to be reviewed by the psychiatrist. The Regional Care Coordinator is given forty-eight (48) hours in which to accomplish this task. The psychiatrist has two (2) options available to him/her. They are:

1. The psychiatrist will review the clinical information. If the submitted information meets the clinical management guidelines in his/her opinion, the review is certified.
2. The psychiatrist, upon review, determines the submitted information does not meet the clinical management guidelines, he/she will "Partially Approve" or "Not Certify" the request. A "partial approval" (i.e., partial certification) should be regarded as a "partial denial". Upon receipt of notification of the above, the provider, legal guardian, or recipient may enter the appeal process.

An informal notification by telephone or fax will be provided by First Health Services regardless of the decision. Formal notification of an authorization/continued stay is forwarded via regular US mail. Denial determinations (administrative or "technical" denials or denial based on "medical necessity criteria") are mailed certified return receipt mail and tracked to ensure delivery.

Notifications for technical denials will include:

- a) Dates of service that are denied a payment recommendation because of non-compliance with Administrative Rule.
- b) Reference applicable federal and/or state regulation.
- c) An explanation of the right of the parties to request an appeal (Administrative Review).
- d) Name and address of person to contact.

Notifications for denial determinations based on “medical necessity criteria” will include:

- e) Dates of service that are denied a payment recommendation.
- f) Case specific denial rationale based on the medical necessity criteria upon which the determination was made.
- g) Date of notice of First Health Services of Montana’s decision, which is the date of printing and mailing and/or the date of the confirmed facsimile transmission.
- h) An explanation of the right of the recipient (or legal guardian), the psychiatrist/physician, and/or the provider to request an appeal.
- i) Name and address of person or office to contact to request an appeal.

Requested services are not subject to Retrospective Review by First Health Services of Montana unless requested by the Department of Public Health and Human Services.

V. THE APPEAL PROCESS

An adverse determination (denial)—“Partially Certified” or “Not Certified”—is received by certified return receipt mail.

The recipient (or legal guardian, the attending psychiatrist/physician, and/or the provider) may request a reconsideration of the adverse determination within the specified time period, thirty (30) days from the date of receipt of First Health Services of Montana’s decision.

The Appeal Request Form may be faxed or mailed to First Health Services of Montana, Helena, Montana at the following address:

First Health Services of Montana
111 N. Last Chance Gulch, Suite 1-B
Helena, MT 59601
FAX: 406-449-6253

It is strongly recommended that a provider attach a concise letter to the appeal form that will allow the appellate physician to better understand the complexities of the case, the clinical justification of the appeal, and any other additional information that would support the continuation of services. Providers should be sure to address the specific questions raised in the initial denial (i.e., why a patient is not taking medications, why a higher level of care is not being pursued at this time, etc.). Multiple page attachments, progress notes, or copies of records are not routinely helpful to the appellate physician; instead, a concise yet detailed summary is the most productive means to convey this information.

The appellate physician is a Board Certified psychiatrist in the State of Montana who has no prior knowledge of the case or professional relationship or ties with the provider/psychiatrist/physician. The requestor may choose either of the following appeal procedures:

1. Peer-to-Peer Review: Peer Discussion (must be completed within three (3) business days of receipt of appeal request). Due to the time constraints associated with peer discussion, please include requestor’s telephone number and at least three (3) available times to complete the review. The appellate physician will contact the requestor. If the appellate physician is unable to contact the provider physician, the appeal will be processed without the peer discussion and will be considered a “desk review”.
2. Desk review: (must be completed within five (5) business days of receipt of appeal request). The desk review consists of the Montana physician reviewing the entire original request for service.

The appellate physician completes the review. The completed review includes the rationale for the determination. If the appellate physician overturns the adverse determination (reverses the Initial Physician Determination), the requestor is notified. If the appellate physician upholds the adverse determination (upholds the Initial Physician Determination), the rationale for the determination and instructions as to the rights of further appeal are included. The appellate physician may partially approve (partially reverse the initial physician determination) meaning he/she can certify a portion of the requested service. The determination rendered by the appellate physician performing the review will, **in all cases**, stand as the final First Health Services of Montana decision.

If the appeal review upholds the adverse determination, the rights of the provider and/or beneficiary to an Administrative Review with the Montana Department of Public Health and Human Services will be included in the formal notification. Further information may be requested by this department to complete the review process.

If an administrative review is requested with the Montana Department of Public Health and Human Services, this request must be submitted, in writing, within thirty (30) days of the receipt of the First Health formal notification (certified letter).

Requests for Administrative Review should be forwarded to:

Pete Surdock
Bureau Chief
Children's Mental Health Division
P.O. Box 202951
Helena, MT 59620-2951
Phone: (406) 444-1290
FAX: (406) 444-1861

When requesting an administrative review, please attach the following information:

- A copy of the original request
- A copy of the initial appeal (include attachments if these were provided with the initial appeal)
- A letter explaining why you believe the appeal decision was in error
- Any additional information to be considered, or information that would support your claim

VI. EXPLANATION OF TERMS

Administrative Denial: (Also termed *Technical Denial*) Prior Authorization Review was not requested according to stated Medicaid protocol and is determined to be in “non-compliance”. Non-compliance indicates that the request and/or information was out of specified timeframes or was incomplete. *Administrative Denials can only be appealed through an Administrative Review with the Department of Public Health and Human Services, Mental Health Bureau. These reviews are not subject to appeal through the regular First Health appeal process.*

Authorization: Determination indicating the utilization review resulted in approval of payment for provider requested services and/or services units and a payment authorization (PA) number is issued.

Appeal: Consumer, provider, or agent’s challenge of a denial (adverse determination). May be initiated through the use of any one of the following terms: Appeal, Administrative Review, Reconsideration, or Fair Hearing.

Certificate of Need (CON): A Certificate of Need (CON) is a State and/or Federal requirement for medical necessity documentation. Requirements for content and signatures vary across services. The CON process is not a guarantee of Medicaid eligibility. The Provider must verify separately that the recipient is eligible for Medicaid and provider First Health with current Medicaid or MHSP number.

Clinical Management Guidelines: The written Montana protocols that define “medical necessity criteria” used to make clinical review determinations.

Continued Stay/Treatment Review: A review of currently delivered treatment to determine medical necessity of a continued level of care. Time frames for review vary across services.

Denial: Request for authorization does not meet the appropriate Medicaid medical necessity criteria to justify Medicaid payments for the services requested. Authorization for payment is denied. Only a First Health psychiatrist may issue a denial.

Desk Review: Process by which an appellate physician reviews clinical information provided in the First Health record as well as additional information submitted by a provider. The appellate physician makes no other contact.

Elective Admission: Elective admission is a scheduled admission that is subject to the choice or discretion of the recipient or the physician advisor regarding medical services and/or procedures that are medically necessary and advantageous to the recipient, but not necessary to prevent death or disability.

Emergency Admission: An emergency admission is a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part, death of the recipient, or harm to another person by the individual.

Fax Based Review: An evaluation in which a reviewer, employed by First Health Services of Montana, reviews a recipient's case via fax. There are three review types: Prior Authorization, Continued Stay/Treatment Review, and Retrospective Review.

Guardian: The recipient's parent, recipients legal guardian, or guardian ad litem.

Partial Approval: An adverse payment determination indicating that the request does not meet the appropriate Medicaid criteria to justify Medicaid payments for the level or complete duration of services requested. Only a First Health psychiatrist may issue a partial approval. *A provider should consider partial approvals a partial denial. A partial approval means that only a portion of the requested service has been approved. If a partial approval is received and the provider believes that further services will be necessary for a recipient, this decision must be appealed. Otherwise, at the end of the approval period, the certification expires and is not eligible for a continued stay review.*

Peer-to-Peer: A telephonic or face-to-face discussion regarding a recipient's medical necessity/clinical information.

Pending Authorization: Indication that a First Health Services of Montana reviewer or First Health psychiatrist has requested additional information from the provider. The provider will have five (5) days to provide any additional information needed to make a payment determination.

Prior Authorization Review: Reviews are performed by First Health Services of Montana for selected services prior to authorizing recommendation for payment and generating a payment authorization (PA) number.

SED: Severe emotional disturbance. See criteria included at end of this document.

SDMI: Serious disabling mental illness. See criteria included at end of this document.

Technical Denial: (Also termed Administrative Denial) Prior authorization review was not administered on medical necessity criteria as a result of provider Medicaid protocol non-compliance. Non-compliance indicates that the request and/or information was out of specified timeframes or was incomplete.

VII. SUGGESTIONS FOR COMPLETING FORMS AND CLINICAL DOCUMENTATION

Always use the most current form, which can be accessed via the DPHHS website (<http://www.dphhs.state.mt.us>). Once on this website, follow these instructions to access the most current forms: (1) Click on the Services link, (2) click on the Forms and Applications link, (3) click on the Mental Health Services Forms link. This should take you to the most updated forms and clinical management guidelines. Check the website frequently, or contact your Regional Care Coordinator for the most updated form.

Forms in general:

- Adobe Acrobat forms are “handwriting friendly”. If you will be downloading to a computer and typing on the form, it is best to download the Microsoft Word version.
- Always ask the questions: why this service, at this level, at this time? What prevents this recipient from being served elsewhere or with a different and/or lower level of service? The review should explain why this particular level of care is necessary
- Remain focused on medical necessity criteria as outlined in the Clinical Management Guidelines.
- Make sure the appropriate CON is completed for higher levels of care.
- Make sure requests are legible. If at all possible, typed requests are easier to read and faster to process. If requests are handwritten, please write as neatly as possible. Felt-tip or “Sharpie” type pens fax better and make a fax more readable.
- Request an accurate number of sessions or treatment days, given the severity of the diagnosis and presentation of the client. This is especially important for outpatient therapy services (i.e., don’t ask for more in anticipation of receiving a portion of the request). Requests for extremely high number of sessions without appropriate clinical documentation of need will assuredly flag the review for deferral. If additional sessions are anticipated for “crisis” situations, you may add these into the request, but substantiate this request with solid clinical data (e.g., this recipient averages a need for a crisis session once every two weeks, etc.)
- In cases of higher level of care, the receiving provider should complete and submit all prior authorization forms, not the placing provider. This ensures that the receiving provider has reviewed all relevant clinical information, can formulate an initial treatment plan and is prepared to treat the recipient. This can be done without the recipient being present. A case manager or placing agent can facilitate getting the clinical information to the receiving provider and can facilitate the completion of the Certificate of Need, but the placing agent should not be completing the authorization paperwork for the receiving provider.

Demographics:

- All relevant diagnoses should be listed, and diagnoses should be consistent across all treatment plans.
- Include a full DSM-IV-TR Multiaxial Assessment (All 5 Axes).
- Do not leave a field blank or leave information out, such as responsible party or zip code. There is certain information that must be included in the request; if omitted, our computer system will not allow the reviewer to move past certain computer screens. Common omissions include: correct birthdate, provider name and correct provider number (if you get forms from another provider, change the form to your provider number). While the reviewer may be able to look up a zip code, this takes extra time, or is especially problematic for larger area with multiple zip codes. The responsible party is generally the parent, or the state agency that has physical custody of the child.

- Be sure to include numerical responses wherever appropriate (e.g., number of outpatient sessions requested, number of treatment days requested for group home or residential services, etc.). Include a start date for your requested span.

Presenting Problems/Symptoms:

- Summarize information on the request and do not include attachments if at all possible. Attachments tend to slow the review process considerably and often provide too much extraneous information that makes it difficult to locate the pertinent information.
- Document discrete, observable behaviors that require treatment. Behaviors identified for planned treatment interventions should be consistent with the diagnoses given. Provide specific examples of how symptoms manifest in this particular recipient (i.e., how is this child oppositional, not just that the child is oppositional).
- Include relevant psychological history that documents baseline behaviors as well as clear indicators of current behaviors.
- Include relevant social history describing family involvement, treatment history, and strengths.
- Notations on severity, progression and duration of pt's symptoms, threat to self/others, nature and effectiveness of previous treatment, support systems and living situation, ability to attend sessions, overall objective of treatment (e.g., symptom removal, rehabilitation, maintenance)

Mental Status (examples in parentheses):

- Appearance (dress, grooming, hygiene, cosmetics, apparent age, posture, facial expression)
- Behavior/activity (hypoactivity or hyperactivity, rigid, relaxed, restless or agitated motor movements, gait and coordination, facial grimacing, gestures, mannerisms, passive, combative, bizarre)
- Attitude (interactions with the interviewer: cooperative, resistive, friendly, hostile, ingratiating)
- Speech (quantity and quality of speech: poverty of speech, poverty of content, voluminous, articulate, congruent, monotonous, talkative, repetitious, spontaneous, circumlocutory confabulating, tangential, pressures, stereotypical, slow/rapid speech)
- Mood and affect (intensity, depth and duration: sad, fearful, depressed, angry, anxious, ambivalent, happy, ecstatic, grandiose, appropriate, apathetic, constricted, blunted flat, labile, euphoric, bizarre)
- Perceptions (hallucinations, illusions, depersonalization, derealization, distortions)
- Thoughts (logical vs. illogical, loose associations, flight of ideas, autistic, blocking, broadcasting, neologisms, word salad, obsessions, ruminations, delusions, abstract vs. concrete)
- Sensorium/cognition (levels of consciousness, orientation, attention span, recent and remote memory, concentration, ability to comprehend and process information, intelligence)
- Judgment (ability to assess and evaluate situations, make rational decisions, understand consequences or behavior and take responsibility for actions)
- Insight (ability to perceive and understand the cause and nature of own and others' situations)

Treatment Plan/Treatment Goals and Objectives/Progress Being Made:

- The fundamental goal of treatment planning is to help mental health professionals make sound therapeutic decisions about their clients and services, so that the clients can ameliorate their difficulties and achieve the goals they have established with the therapist. A need for accountability as well as for effectiveness mandates systematic treatment planning. Unfortunately, treatment planning is frequently viewed as a process that must be done to satisfy bureaucratic requirements. Although this might be somewhat true, the fundamental reason behind treatment planning is to facilitate effective treatment.

- Treatment plans should always be outcome-based and would be expected to differ based on the level of care being provided. Regardless of treatment modality, short-term contracts and concrete, readily attainable goals, should be established. Progress should be assessed at regular intervals. Interventions should have a specific focus, which could be broken down in terms of general expectations and specific services geared to meet those expectations. Treatment plans should reflect individualized attention to the recipient's needs and should note any services unique to the program structure in which the recipient is involved.
- Goals should change as recipients and counselors develop a working relationship, and new goals will supplant old ones as gains are made. Goals are necessary in order to develop a treatment plan, to assess progress, and to give direction to the counseling process.
- Goals selected should be clear and measurable. Exactly how will the recipient know when they are getting along better with others (e.g., will they have fewer fights with colleagues, have lunch with friends more often, or have a longer list of social contacts).
- Do not use the treatment plan section to detail the pt's life situation, but to focus on the plan of care that will be provided. Report appropriate social history information as it pertains to the current problems and current plan of care.
- Be sure to document progress being made in addition to problematic behaviors that necessitate the continuation of the service being requested.
- Document family treatment sessions and outcomes, whenever applicable. If there is a lack of family participation or lack of progress, what interventions are planned, or what is the plan to involve other supportive agencies/entities in this family intervention? If family therapy is contraindicated, provide information as to why this is the case.
- Provide details specific to interventions being used with recipients, not just information provided on the treatment modality being used.
- If the recipient is receiving services from more than one provider, all treatment plans should reflect how the services are coordinated and supportive to avoid the duplication of efforts.

Medications:

- Include medications and dosage information.
- Note any recent medication or dosage changes, discontinuation (and reasons why) and dates.
- Indicate any medical conditions, which are to be taken into consideration.

Discharge Plan/Discharge Criteria/Outcome Measurements:

- Discharge planning begins at the time of admission.
- There should be a clear discharge plan that can be realistically implemented. Discharge plans should include a plan for safely placing the recipient in a less restrictive level of care and how the community treatment team will be informed and utilized in discharge planning.
- Discharge outcomes should be individualized to the recipient and the pt's situation.
- Discharge outcomes should be measurable and mutually formulated with the recipient/family. They should be realistic and achievable in relation to the pt's current and potential capabilities and available sources and support system. Outcomes should serve to provide direction for continued, effective management of care and can include a predicted time estimate for attainment based on the provider's accumulated knowledge and experience as to when specific outcomes are typically achieved. The discharge plan is a projected timeline of the influence that interventions will have on the client in relation to the identified problem.

- “Not applicable” is not an appropriate response in this section. If a discharge plan is precluded by certain circumstances, then this should be detailed and a plan of action to address these issues should be included.

VIII. COMMON REASONS FOR PHYSICIAN DEFERRALS OR DENIALS

1. Lack of clinical documentation

- Lack of clinical and behavioral documentation when a change of diagnosis occurs
- Lack of information related to discrete, observable behaviors exhibited in the recipient that clearly relate to the current diagnosis and current treatment plan
- Failure to update and amend treatment plans as treatment progresses (many times reviews are deferred because the provider notes no updates after the initial treatment plan)

2. Length of Stay

- Lack of clinical documentation to justify continued care at any given level (Why does this recipient continue to need THIS level of service at THIS time? What are the circumstances necessitating this level of care?)
- Lack of documentation of provider's efforts to move this recipient toward a less restrictive level of care. What efforts have been made toward doing so?

3. Medication Issues

- Providers should include reasons for why medications are not prescribed for a recipient (e.g., parent objection, age of recipient, history of medication non-compliance, lack of previous efficacy of medications). Reviews are frequently deferred for physician review due to reports of significant behavioral disturbance with little to no medication prescribed.
- Reviews are frequently deferred to the physician if the medication prescribed does not correspond to a) the behaviors described (e.g., hallucinations), b) the diagnosis given (e.g., stimulant medication is prescribed but no behaviors reports support this)

4. Family therapy

- Deferrals routinely occur at the RTC level of care where no family therapy is reported, yet the discharge plan indicates a return to the family home.
- Unless there is a clear indication as to why family therapy is contraindicated (i.e., termination of parental rights, parental incarceration, DCFS involvement which precludes contact with the parent), regular, preferably weekly, family therapy sessions are generally expected.
- Family therapy sessions and the outcomes of these sessions should be clearly documented with regard to issues address and progress being made.

5. Mental Status Information

- The recipient's mood, affect and behavior should be clearly documented. This section should not be used to document the recipient's specific behaviors (e.g., child is routinely oppositional toward parent), rather it should be a general descriptor of how the recipient acts and interacts. Specific information regarding thought process should be included. This section does not need to be a formal mental status exam, but should include details that give the reviewer an idea of the recipient's functional level and ability to interact with others.

6. Discharge Planning

- Discharge plans should indicate an estimated discharge date. If changes are made to a discharge date, the provider should document reasons for the change.
- Discharge plans need to be REALISTIC. It is not realistic to indicate that a recipient will step-down to a group home if funding is not available for that level of care. It may be the case that a provider needs to pursue a two-pronged discharge plan in the case of potential family reunification through a DCFS treatment plan, but the provider needs to clearly indicate how both plans are being pursued simultaneously.

IX. DOCUMENTATION EXAMPLES

Examples of presenting problems:

Poorly Written	Better	Best
Bill has hallucinations and delusions	Bill hears voices and has some delusional symptoms	Bill hears a male voice tell him to harm himself approximately 4x per day; he also exhibits a delusion that he is Jesus Christ
Kate is oppositional and defiant	Kate refuses to follow parental directions, disregards mother's authority and deliberately annoys others	Kate talks back to parents on average 5x per day, refuses to complete household chores, disregards curfew and refuses to comply with punishments as issued by parents.
Poor academic performance	Sally is performing below grade level and has difficulty paying attention in the classroom	Due to Sally's attentional difficulties, she is unable to focus on instruction in the classroom, frequently needs redirection from her teacher, and is unable to complete assignments in a thorough or sufficient manner without 1:1 assistance.
Mike is chronically mentally ill	Mike has a 15 year history of mental illness and is unable to live on his own	Mike has a 15-year history of chronic mental illness that has included numerous admissions to Warm Springs. He is unable to perform ADLs without numerous daily prompts, is unable to manage his finances. He has a payee for SSI. Patient continues to exhibit significant auditory and visual hallucinations and is frequently paranoid about staff intentions to assist him.

Examples of outcome-based treatment plans:

Poorly Written	Better	Best
Jimmy will decrease impulsivity	Jimmy will be less intrusive and will not be so bothersome in the classroom.	Jimmy will remain in his seat for 20 minutes without disrupting or disturbing others as observed by his teacher.
Stan will increase socialization.	Stan will be more open to social interactions.	Stan will make self-directed statements at least once per process group attended
Medication compliance.	Betty will take her medications regularly	Betty will take her medications without prompting each day
Provide a safe, structured environment to enable the patient to work on her issues.	In the context of the structured program of the group home, Samantha will learn better boundaries and will not act out behaviorally.	In the context of the structured program of the group home, Samantha will learn how to maintain personal space, decrease sexualized behaviors, decrease the need to become physically and verbally aggressive when demands are made on her, increase her ability to verbalize her needs, and increase her identify her emotional needs and verbalize her feelings.

Examples of discharge plans:

Poorly Written	Better	Best
Bob will be discharged to a lower level of care when appropriate behaviors are maintained.	Bob will be discharged to a therapeutic group home once goals of residential treatment are attained. EDD 2 years.	Discharge criteria: Bob will not be physically aggressive, will respond 80% of the time to verbal redirection, will increase verbalizations of emotional needs and will eliminate self-injurious behaviors. Estimated discharge date is 12 months, but discharge plan will be evaluated every 30 days. Case manager is currently making referrals to therapeutic group homes in the child's home community.
Kelly will be discharged to therapeutic foster care.	Case manager will be locating a therapeutic foster care placement at a local agency within the next three months.	Case manager is currently working with local therapeutic foster care providers to secure a placement, which should take place within the next 30 days. Kelly is nearing discharge, as almost all presenting the problems have been stabilized, with the exception of patient's anger outbursts. Over the next 30 days, specific work will be done to teach patient how to better manage anger and set expectations for TFC placement.
Jack will be discharged to his mother.	Jack will be discharged in 6 months to the care of his mother.	Discharge criteria: Jack will verbalize and resolve anger toward parent through family therapy; he will decrease aggression and episodes of anger dyscontrol; he will take medications consistently; mother will learn new techniques to communicate more effectively and set appropriate limits and boundaries for patient. Case manager is in the process of making referrals to family support services, which will be implemented upon discharge. EDD 6 months.
Not applicable	Discharge cannot be implemented at this time due to lack of involvement from other agencies.	Discharge planning is complicated by the lack of collateral involvement, which would fund room and board payments for either group home or foster care. Jim is currently stable. Case manager is currently working to secure family support services for the parent, as this is the best community option available at this time.
Mary cannot be discharged due to chronic mental illness.	Mary cannot live independently due to chronic issues related to psychiatric symptoms (ongoing schizophrenic symptoms which, while managed with medication, do not allow her to function independently).	Mary will likely need the ongoing support of an adult group home or an adult foster care environment, as she is unable to live independently and care for himself due to severe schizophrenia. The treatment team will continue to work to build her independent living skills, improve ADLs, and help her to learn the need for medication to manage her symptoms, with the goal to place her in the least restrictive level of care possible. At this time, adult foster care appears to be the most appropriate and least restrictive level of care. There is no discharge date from this level of care; however, Mary's treatment plan will be reviewed every 90 days to monitor progress and assess for suitability for independent living.

X. THE FOCUS OF TREATMENT FOR EACH LEVEL OF CARE

In all levels of care, treatment should focus on the behaviors that prompted the admission. As the recipient makes progress through treatment, it is expected and understood that goals will be reviewed and changed. However, specific goals should be developed upon admission that identify the criteria by which discharge will be deemed appropriate.

Assessment for appropriate level of care should be an ongoing discussion among treatment team members. When a recipient is screened for mental health services, risk assessments should be conducted to determine if higher levels of care should be immediately considered. When a treatment team is considering a change in service intensity, team members should keep in mind these general expectations for different levels of care.

Acute Inpatient Services: The focus of this level of care is to treat symptoms and stabilize behaviors of such severity that the absence of immediate psychiatric intervention might lead to increased serious dysfunction, death, or harm to self or others. Placements at this level of care are expected to be short-term.

Montana State Hospital Acute Care: The focus of this level of care is geared toward the chronically mentally ill and is similar to that of Acute Inpatient Services. Stays at this level of care are generally much longer than an acute stay in a community hospital setting.

Youth Residential Treatment: This is the highest level of care for children, other than Acute Inpatient Care. Children should be referred to this level of care when: (a) interventions at lower levels of care (e.g., therapeutic foster care, intensive outpatient or partial hospitalization services) have failed to meet the child's needs in the community setting; or (b) the child's behavior is so dangerous or destructive that he/she requires 24-hour per day treatment under the direction of a physician. RTC services should be prepared to meet a child's psychosocial needs, including educational goals. If a child has an IEP upon admission to the facility, then that facility must follow the educational plan as outlined in the IEP. If a child does not have an IEP upon admission and the child's educational plan is compromised due to emotional or behavioral issues, it is expected that a written referral to the home school district be made prior to the pt's discharge from the facility in order to facilitate access to services upon the pt's return to the home community. The RTC should clearly document that educational needs are being addressed.

Adult Crisis Stabilization Services: The focus of this level of care is to treat symptoms and stabilize behaviors of significant severity which are not severe enough to warrant acute inpatient hospitalization, but require a safe environment to monitor behaviors. Such behaviors may include but are not limited to: self-injurious behavior or threats of harm to self or others; suicidal ideation with ability to contract for safety; self-destructive behavior or ideation that cannot be adequately managed and/or treated at a lower level of care without risk to the recipient's safety or clinical well-being; history of chronic self-

destructive or self-mutilation or impulsive behavior; grave psychiatric disability which renders the recipient unable to care for self; an acute exacerbation of psychiatric symptoms; deterioration of the recipient's functioning in the community; an inability or refusal of the recipient to participate in their own treatment plan; or an inability for a physician to accurately diagnose a recipient due to non-compliance or unusually complicated clinical presentation. Crisis stabilization services are also expected to be short-term in nature with a clearly developed discharge plan to move the recipient to a lower level of care in the safest and most efficient way possible.

Acute Partial Hospital Care Services: The focus of this level of care should be on the stabilization of immediate behaviors and reducing the risk of behaviors destructive to self or to others, including impulsive behaviors such as mutilation, reducing clinically significant disability, reducing the probability of behaviors likely to lead to a higher level of care and reducing the medical risk factors that are associated with a mental disorder and place the recipient at risk. Typically, the recipient at this level of care has been hospitalized in acute inpatient services and is "stepping down" to a less restrictive environment. The referral source should have clear documentation of severe behavior which, if left untreated, could lead to a significant decompensation and/or a higher level of care. The recipient's behavior would indicate a significant functional impairment in home, school/work, community, peer group, or social roles. There should be clear indicators of the recipient's level of ability to function outside of the program and specific goals should be set toward transition of the recipient back into a community treatment setting. Family therapy sessions should occur regularly at this level of care unless contraindicated or unavailability of the family. The treatment focus should not be on cognitive restructuring of the recipient's issues (this would be done on outpatient or other therapy once the pt has stabilized).

Sub-acute Partial Hospital Care Services: The focus of this level of care should be on stabilizing a recipient's maladaptive behaviors or poor skills which have contributed to a failure of outpatient interventions, but do not yet warrant a higher level of care. Goals are similar to that of Acute Partial Hospital Care Services, but the severity of the behaviors is less.

Therapeutic Living Services/Therapeutic Group Homes: The focus of this level of care should be on the behaviors which result in the need for a higher intensity of, and accessibility to, therapeutic interventions than are available through traditional outpatient services, and which clearly exceed the capabilities of immediate family, relatives, friends, or other community systems. The referring agent should document the need for the child to be out of a biological or foster family's home (or the need for an adult to be out of a community or independent living environment) and describe behaviors or situations that prevent immediate return to the home or community environment. The focus of treatment should be on longer-term stabilization of behaviors and assisting the recipient to learn specific skills necessary for him/her to function within a family environment or in an independent living situation. Specific goals should be developed to address behavioral progress at school/work and in the community, including compliance with meeting outpatient requirements (scheduled appointments, taking medications). There

should be adequate documentation of the need for supplemental (e.g., outpatient therapy, day treatment) services for recipients at this level of care.

Therapeutic Living Services/Therapeutic Family Care: The focus of this level of care is similar to that of a group home, but emphasis should be placed on why this recipient is not able to live in the biological/adoptive family and instead needs the support of therapeutically-based foster care services OR why the biological/adoptive family requires additional supports to maintain a child in the home environment. Providers need to delineate what type of therapeutic family care is being provided. Focus should be on increasing the recipient's skills and ability to live in a family environment, and on outpatient treatment compliance with already developed treatment goals to manage the recipient's behaviors. Intensive TFC should document the use of a therapeutic aid for ten (10) hours per week and the specific issues the aid is working to address with the child. The use of the therapeutic aid should be primarily therapeutic, not recreational in nature (although some structured recreational activities geared toward treatment plan goals is certainly appropriate). The provider should indicate treatment goals and family's ability to attain and implement these goals.

Outpatient Therapy Services: This is the least restrictive level of care available. This level of care is directed toward reversing symptoms of mental or emotional disorders while maintaining stability and functional autonomy for the recipient. Outpatient services should be specific in targeting the symptoms and/or problems being treated. Recipients at this level of care should not present as a risk to self or others, should not require a level of care that includes more intensive medical monitoring, and should exhibit a degree of impairment in functioning arising from a mental or emotional disorder. Outpatient therapy should reasonably be expected to reverse symptoms or contain symptoms such that a higher level of care is not necessary.

X. SUGGESTIONS FOR DEVELOPING OUTCOME-BASED TREATMENT PLANS

Appropriate treatment planning and documentation begins with a thorough clinical assessment that provides an overall conceptualization of the recipient's clinical needs and problems. Problems need to be considered in light of a recipient's environment in order to develop the most appropriate and effective treatments possible. The clinical assessment should constitute the major source of information for the team. Once a thorough assessment is completed, the work of treatment planning can begin.

One can look at treatment planning in the context of three issues: centrality, proactivity, and reality.

Centrality

The focus of the treatment plan should be the problems most immediately requiring treatment at the proposed level of care. Refine the problem statements by asking the following "why now" questions: Why is this service needed? Why this level of care? Why is this service needed right now?

Common factors contributing to the "why now" might include: stresses in primary support group, work/school life, environmental stressors (e.g., moves, natural disasters, abrupt change in daily routine, etc.), medical stresses, developmental stresses (e.g., 1st time away from home, puberty, emancipation, middle age, aging, etc.), internal stresses (e.g., excessive differential between expectations of self and reality)

Keep the treatment focused on the problems that brought the recipient to this level of care, until these problems have been resolved, or the problem becomes more clearly redefined.

In identifying clinical needs and problems, vague terms, (e.g., "unacceptable social behavior," "delusional," "hallucinating," "assaultive") are not considered behaviors. Behaviors are what an individual does (e.g., "the recipient talks to himself as if in response to voices") and says. Clinical problems need to be identified and individualized with regard to the specific recipient, not described in general terms. How a child is oppositional is much more important in treatment planning than knowing that "the child is oppositional". Identifying the "hows" of a recipient's behavior can ultimately lead to understanding the "whys" of a recipient's behavior, and thus hopefully lead to a resolution of the triggers to the problem.

It is necessary for treatment teams to prioritize treatment problems so that the focus of treatment can remain on the most severe issues. It is simply impossible to treat 20 problems at one time. Such problem areas might be identified through the clinical assessment, the administration of the CAFAS, or by recipient report. Remember, the focus of treatment should be to alleviate or reduce significant problem behaviors so that the recipient can function in the least restrictive level of care.

Proactivity

Treatment teams should develop specific interventions with measurable goals and objectives to actively address the presenting behaviors or problems. Part of this planning involves estimating a timeframe for completion of smaller objectives, completion of larger goals, and discharge from services (or discharge to lower levels of care). The treatment team should identify discharge criteria by which progress will be measured and on which the removal or reduction of services will be based. Goals need to be realistic, capable of measurement, and achievable. Objectives are shorter-term, smaller goals, which, when put together, result in the attainment of the larger goal. The length of time to achieve short-term objectives should always be specified. Short-term objectives help treatment teams and the recipient break unmanageable problems into smaller pieces and create “stepping stones” toward the completion of larger treatment goals.

All treatment team members should play an active role in helping to define the problems and to develop an agreed-upon plan of action to address these problems. If there are multiple providers, there should be a unified plan on which each provider bases treatment. Multiple providers with multiple treatment plans are not only inefficient for the recipient, they are confusing and often contradictory.

Again, focus on the “why now” questions and develop goals specific to the identified problem areas.

- What does the recipient/family hope will be different as a result of the treatment? Are the expectations clear? Are they realistic?
- How will we know when the treatment goals are met (in measurable/observable/functional terms)?
- What is the projected time frame for meeting the goals and objectives?
- Who will do what to help the recipient/family meet the goals? Are the planned interventions the type of service that is likely to help the identified problem?
- Is everyone involved that needs to be involved in solving the problem? Parents, schools, probation, employers, etc. are frequently left out when they might be very helpful.
- Is everyone WILLING to do his part in solving the problem, as measured by both stated agreement and follow-through? If this is not clear, the treatment needs to refocus on the workability of the original plan, revision of goals, or the possibility that there is no real agreement currently for change. The case manager can play an invaluable role in spotting signs of lack of agreement and bringing this to the attention of providers so this can be dealt with and the treatment does not drift.
- Will this recipient have long-term needs for service once the immediate goals are met? What will these be? In what settings can these best be met? What actions are being taken now to plan for this? Who is doing what? Good long range discharge planning is the best way to reduce recidivism.

Reality

Finally, the reality of the plan needs to be considered. Is the recipient being set up to fail? Are expectations too low or too high? Is there a reasonable likelihood that this recipient will benefit from services?

Are the following resources being considered?

- Community resource availability
- Financial resources (personal financial resources and insurance/Medicaid/SSI benefits)
- Family resources
- Intellectual/physical/emotional resources and limitations

Problems in community living are a vital area to address in treatment planning. When such issues are not addressed as part of the treatment plan, it is highly likely that the recipient will return to a higher level of care, simply because they have not been adequately prepared to adjust back to the community environment. This is especially true for recipients who have been in a residential facility with little to no family work completed; once discharged, the recipient may fall back into old patterns of behavior and coping skills, and all the time, effort and money spent on a recipient is essentially wasted. Treatment teams should regularly ask, “if this recipient were to return to the community at this time, what would prevent him or her from being successful in that setting?”

Long-term goals must be realistic and appropriate. The treatment focus may be on improving the recipient’s condition, maintaining the recipient’s condition, or slowing the deterioration of a recipient’s condition. But the bottom line is that the goals should be functional, methodical and ultimately beneficial for the recipient.

XII. DEFINITION OF SERIOUS EMOTIONAL DISTURBANCE (SED)

April 2001

"Serious emotional disturbance" (SED) means with respect to a youth between the ages of 6 and 17 years that the youth meets the requirements of (a), and either (b) or (c).

(a) The youth has been determined by a licensed mental health professional as having a mental disorder with a primary diagnosis falling within one of the following DSM-IV (or successor) classifications when applied to the youth's current presentation (current means within the past 12 calendar months unless otherwise specified in the DSM-IV) and the diagnosis has a severity specifier of moderate or severe:

- (i) childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90);
- (ii) oppositional defiant disorder (313.81);
- (iii) autistic disorder (299.00);
- (iv) pervasive developmental disorder not otherwise specified (299.80);
- (v) Asperger's disorder (299.80);
- (vi) separation anxiety disorder (309.21);
- (vii) reactive attachment disorder of infancy or early childhood (313.89);
- (viii) schizo affective disorder (295.70);
- (ix) mood disorders (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89);
- (x) obsessive-compulsive disorder (300.3);
- (xi) dysthymic disorder (300.4);
- (xii) cyclothymic disorder (301.13);
- (xiii) generalized anxiety disorder (overanxious disorder) (300.02);
- (xiv) posttraumatic stress disorder (chronic) (309.81);
- (xv) dissociative identity disorder (300.14);
- (xvi) sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89);
- (xvii) anorexia nervosa (severe) (307.1);
- (xviii) bulimia nervosa (severe) (307.51);
- (xix) intermittent explosive disorder (312.34); and
- (xx) attention deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the diagnoses listed above.

(b) As a result of the youth's diagnosis determined in (2)(a) and for a period of at least 6 months, or for a predictable period over 6 months, the youth consistently and persistently demonstrates behavioral abnormality in two or more spheres, to a significant degree, well outside normative developmental expectations, that cannot be attributed to intellectual, sensory, or health factors:

- (i) has failed to establish or maintain developmentally and culturally appropriate relationships with adult caregivers or authority figures;

- (ii) has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships;
 - (iii) has failed to demonstrate a developmentally appropriate range and expression of emotion or mood;
 - (iv) has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation settings;
 - (v) has displayed behavior that is seriously detrimental to the youth's growth, development, safety or welfare, or to the safety or welfare of others; or
 - (vi) has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.
- (c) In addition to mental health services, the youth demonstrates a need for specialized services from at least one of the following human service systems during the previous six months:
- (i) education services, due to the diagnosis determined in (a), as evidenced by identification as a child with a disability as defined in 20-7-401(4), MCA with respect to which the youth is currently receiving special education services;
 - (ii) child protective services as evidenced by temporary investigative authority, or temporary or permanent legal custody;
 - (iii) the juvenile correctional system, due to the diagnosis determined in (a), as evidenced by a youth court consent adjustment or consent decree or youth court adjudication; or
 - (iv) current alcohol/drug abuse or addiction services as evidenced by participation in treatment through a state-approved program or with a certified chemical dependency counselor.
- (d) Serious emotional disturbance (SED) with respect to a youth under six years of age means the youth exhibits a severe behavioral abnormality that cannot be attributed to intellectual, sensory, or health factors and that results in substantial impairment in functioning for a period of at least 6 months or is predicted to continue for a period of at least 6 months, as manifested by one or more of the following:
- (i) atypical, disruptive or dangerous behavior which is aggressive or self-injurious;
 - (ii) atypical emotional responses which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations;
 - (iii) atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent or hypersexual;
 - (iv) lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction;
 - (v) indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal safety of the child; or
 - (vi) inappropriate and extreme fearfulness or other distress which does not respond to comfort by caregivers.

XIV. SEVERE DISABLING MENTAL ILLNESS CRITERIA (SDMI)

January 2004

“Severe disabling mental illness” means with respect to a person who is 18 or more years of age that the person meets the requirements of (a) or (b) or (c). The person must also meet the requirements of (d):

- (a) has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital at least once; or
- (b) has a DSM-IV diagnosis of
 - (i) schizophrenic disorder (295);
 - (ii) other psychotic disorder (295.40, 295.70, 297.1, 297.3, 298.9, 293.81, 293.82);
 - (iii) mood disorder (296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 293.83);
 - (iv) amnestic disorder (294.0, 294.8);
 - (v) disorder due to a general medical condition (310.1); or
- (vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation;
- (vii) anxiety disorder (300.01, 300.21, 300.22, 300.3) or
- (c) has a DSM-IV diagnosis of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least 6 months (or for an obviously predictable period over 6 months); and
- (d) has ongoing functioning difficulties because of the mental illness for a period of at least 6 months (or for an obviously predictable period over 6 months), as indicated by at least two of the following:
 - (i) medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;
 - (ii) the person is unable to work in a full-time competitive situation because of mental illness;
 - (iii) the person has been determined to be disabled due to mental illness by the Social Security Administration;
 - (iv) the person maintains a living arrangement only with the ongoing supervision, is homeless, or is at risk of homelessness due to mental illness; or
 - (v) the person has had or will predictably have repeated episodes of decompensation. An episode of decompensation includes:
 - increased symptoms of psychosis
 - self-injury
 - suicidal or homicidal intent, or
 - psychiatric hospitalization.